EXHIBIT 15

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THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS
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In re: PHARMACEUTICAL, INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION	MDL DOCKET NO. CIVIL ACTION 01CV12257-PBS
THIS DOCUMENT RELATES TO: ALL ACTIONS	

DEPOSITION OF DUANE PRESHINGER
Taken at:
Law offices of
Gough, Shanahan, Johnson & Waterman
33 South Last Chance Gulch
Helena, Montana
April 20, 2006
9:00 a.m.

Q. (By Ms. Smith-Klocek) So does the usual and customary price include customers who are covered by private insurers?

MS. BRECKENRIDGE: Objection.

THE WITNESS: I would assume so, yes.

Q. (By Ms. Smith-Klocek) I'd like you to turn to Section 9.1.

A. Okay.

Q. Where it says "Completing a Paper Claim", do you see that?

A. I do.

Q. It refers to a Claim Form MA-5.

A. Yes.

Q. Is Form MA-5 the form used by pharmacists to submit a claim to Medicaid for a prescription drug?

A. I believe so, yes.

Q. Do you know or --

A. I've never dealt with pharmacy claims on a claim-by-claim basis.

Q. Turning the page where it has a chart where there's "Field Title" and "Instructions"

across the top, do you see that?

A. I do.

Q. And down to Field No. 19 where it says "Amount Charged", what is a pharmacist supposed to enter into the "Amount Charged" field?

MS. BRECKENRIDGE: Objection; foundation, form.

THE WITNESS: I guess reading it, it says: "Enter the pharmacy's usual and customary charge including dispensing fee."

Q. (By Ms. Smith-Klocek) Does this section "Completing Paper Claims", Section 9.2 -- I guess these are pages, so Section 9, pages 1 through 4. Is this section intended to instruct pharmacists on how to submit a claim to Montana Medicaid for prescription drugs?

A. It provides guidance regarding them submitting a paper claim to Medicaid.

MS. SMITH-KLOCEK: Could you please mark this as Exhibit Preshinger 002?

(Document marked Deposition Exhibit Preshinger 002 for identification.)

MS. SMITH-KLOCEK: For the record, I have marked as Exhibit Preshinger 002 a one-page document entitled Form No. MA-5. Across the top, it says "State of Montana - Dept. Of Public Health & Human Services."

THE WITNESS: (Perusing document) -- okay.

Q. (By Ms. Smith-Klocek) Do you recognize this document?

A. It's the form that's in the manual.

Q. Okay. Is this a blank copy of the Form MA-5 that is used by pharmacies to submit claims to Medicaid for prescription drug reimbursement?

A. Yes.

Q. Okay. I'm done with that.

Do you recall a time when Montana Medicaid sought to change its reimbursement formula for prescription drugs from AWP minus 10 to AWP minus 15?

A. Yes.

Q. Okay. In 2002 your role was Acute Services section supervisor, right?

A. Correct.

invoice prices was 19.71 for brand name drugs and 65.37 percent for generic drugs."

Do you want me to continue?

Q. No, you're fine. Given that study, do you know why the proposal to change met the reimbursement formula for prescription drugs under the Medicaid program was for AWP minus 15 percent rather than a greater number discount off of AWP?

MS. BRECKENRIDGE: Objection.

THE WITNESS: At the time, we weren't -- after having read the report, we did not know anything they took into consideration. We don't know who they had studied with, who they had talked to, or how they had gotten their data. The job of Montana Medicaid is to ensure that the Medicaid clients continue to have access to prescription drugs. Many pharmacies are the -- in many communities, there's only one pharmacy. And so it's not our -- it's our obligation to make sure those community pharmacies continue to stay open and they continue to have access to them. That AWP less 15 percent was just a middle number in regards to what

methodology has been in place since July 2002. Since that time, the State's financial position has worsened causing the Division to cut back services and reimbursement to providers."

Was part of the impetus for this proposal to AWP minus 25 percent an effort to reduce the Medicaid budget?

A. Yes.

Q. In the next paragraph in the middle of the paragraph, do you see where it starts -- let's start with "However, the Division". Do you see that?

A. Where is that?

Q. It's about seven lines down: "However"?

A. Okay, I've got it. Thank you.

Q. Could you read from there -- I'm sorry, it's three sentences.

A. "However, the Division does realize that significant cost savings can be realized by incorporating a multi-tiered reimbursement system, specifically by changing the reimbursement rate for generic multiple source drugs without FULs at a rate consistent with those noted in the OIG report. It

BY MS. SMITH-KLOCEK:

Q. And did Montana Medicaid understand that those costs would be included in the AWP minus 25 percent number?

MS. BRECKENRIDGE: Objection.

THE WITNESS: Can you repeat that, please?

Q. (By Ms. Smith-Klocek) Let me rephrase it. Was it your understanding that the reimbursement for AWP minus 25 percent for generic drugs would be adequate to compensate pharmacists for their professional services and costs of dispensing?

A. Overall in the aggregate, yes.

Q. Do you recall what the outcome was for the this AWP minus 25 percent proposal?

A. We later withdrew it.

Q. Do you recall why?

A. We withdrew it as the Congress, Federal Congress had passed a change in our Medicaid matching dollars that increased, I believe, right around 3 percent our federal Medicaid match. So we were no longer in the hole, so to speak. We weren't -- (pause.)

Q. Part of the reason for withdrawing the AWP minus 25 percent proposal for generics was because you no longer had the budget restraints that was the impetus for proposing it in the first place?

A. Right.

MS. BRECKENRIDGE: Objection.

THE WITNESS: That's one of the reasons.

Q. (By Ms. Smith-Klocek) Was another reason for the Department's withdrawal a result of provider opposition to the rule change?

A. There was provider opposition, yes.

Q. Was provider opposition part of the consideration for withdrawing the AWP minus 25 percent proposal?

MS. BRECKENRIDGE: Objection.

THE WITNESS: It was one of the things that was taken into consideration, yes.

Q. (By Ms. Smith-Klocek) Did you receive comments or complaints from providers regarding the AWP minus 25 percent proposal?

A. I don't recall. I assume we did.

MS. SMITH-KLOCEK: Could we please mark

to already to get their food and things like that. So we don't cover for them right now.

Conceivably, if there was more distance that they had to travel in order to get to that, could we? We could, but that's making the assumption that all the pharmacies would quit in those rural communities.

Q. So in determining the level of reimbursement for pharmaceutical drugs, is access an important consideration for Montana Medicaid?

A. Yes, it is.

MS. SMITH-KLOCEK: What's the next number?

COURT REPORTER: Ten.

MS. SMITH-KLOCEK: Would you please mark this as Exhibit Preshinger 010?

(Document marked Deposition Exhibit Preshinger 010 for identification.)

MS. SMITH-KLOCEK: Exhibit Preshinger 010 is a two-page document Bates-stamped MT 025511 through MT 025512.

THE WITNESS: (Perusing document.)

BY MS. SMITH-KLOCEK:

Montana Medicaid, you use J-codes?

A. The physician program does, yes.

Q. Do you know who within Montana Medicaid has responsibility for setting reimbursement rates for physician-administered drugs?

A. The bureau chief is Mary Angela Collins, the division program officer is Denise Brunett.

Q. Do you recall having any discussions with Denise Brunett regarding reimbursement rates for drugs?

A. Not specifically, no.

Q. Do you recall any e-mails or communications with Denise Brunett regarding reimbursement rates for drugs?

A. Not specifically, no.

Q. Do you recall any conversations or communications with Mary Angela Collins regarding reimbursement rates for physician administered drugs?

A. I don't recall.

Q. Where did you obtain your understanding that physician-administered drugs are reimbursed at

an AWP minus formula?

A. Just I think it's been talked about like in meetings, you know, like management meetings, or whatever, that kind of stuff. They have worked with -- I believe they have worked with Dan in regards to that pricing methodology.

Q. What kind of management meetings are you referring to?

A. Well, we have regular like division management meetings, and then there's also -- those are the ones the bureau chiefs attend, supervisors attend. I don't know if that was where I heard that or not.

Q. Do you know when you came to this understanding?

A. No. I don't delve into the day-to-day of the pharmacy realm. I mean that's why there's program officers that do that.

Q. Before we break for lunch, just a couple follow-up questions. You mentioned that Julie Frickle is an analyst in your section. What kind of reports does she generate?

OIG?

A. Yes.

Q. Dan Peterson, at this time, directly reported to you?

A. Yes.

(Document marked Deposition Exhibit Preshinger 022 for identification.)

MS. SMITH-KLOCEK: What's been marked as Exhibit Preshinger 022 is Exhibit MT 023670 through MT 023700. It's entitled "Office of Inspector General, Medicaid Pharmacy - Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products", dated September 2002, I believe.

THE WITNESS: (Perusing document) -- okay.

BY MS. SMITH-KLOCEK:

Q. Are you familiar with this document?

A. I don't recall it specifically, no.

Q. In your position as Acute Services section manager -- I'm sorry, section chief and Acute Services bureau chief, do you receive OIG reports regarding prescription drug surveys?

A. Typically, yes.

Q. Do you receive OIG reports regarding acquisition costs of prescription drugs?
A. Typically, yes.
Q. In your time at Acute Services in Montana Medicaid, do you recall how many OIG reports you've received?
A. I do not.
Q. How do you receive these OIG reports?
A. Typically, on paper; although more recently, I think they have sent some electronically.
Q. Who do you receive them from?
A. It depends. Typically, from like John Chappuis, the State Medicaid Director, or whoever gets them sometimes.
Q. Who else at Montana Medicaid gets them?
A. You would probably be surprised on random people they send things to. I'm sure Jeff Buska probably got some, Gail Gray, Maggie Bullock.
Q. When you say "they" send, are you referring to CMS or OIG?
A. Right.

Q. Is that Montana Medicaid's response to the request for description of all efforts adopted by Montana to reduce Medicaid prescription drug costs?

A. Yes.

Q. And in the request, it requests -- it refers to Maximum Allowable Cost lists. Are you familiar with Maximum Allowable Cost lists, or otherwise known as "MAC lists"?

A. We don't have them in Montana, but I understand what they are.

Q. Let's start with your understanding of what they are.

A. From my understanding of what they are, it's where states would go out and survey and set a maximum allowable cost for a certain drug.

Q. Is it your understanding that MAC lists are intended to reduce Medicaid prescription drug costs?

A. I would assume so, yes.

Q. And does Montana have a state MAC list?

A. No; no, we don't.

Q. Has Montana considered implementing a

state MAC list?

A. We have looked at that, yes.

Q. Do you recall --

MS. SMITH-KLOCEK: I'm sorry, on the telephone, whoever is typing, could you please mute your telephone?

Q. (By Ms. Smith-Klocek) When did Montana Medicaid consider implementing a state MAC list?

A. I don't recall.

Q. But you recall it was during your tenure?

A. Yes.

Q. So since 2002?

A. Yes.

Q. Who was involved in those discussions?

A. I don't recall specifically. I would assume Dan Peterson and probably Jeff Buska.

Q. Do you recall why Montana Medicaid decided not to implement a state MAC list?

A. I don't recall specifically the reason, no.

Q. During your tenure, has Montana Medicaid considered implementing a state MAC list more than

once?

A. I don't believe so.

Q. The last item on this list is with regard to supplemental rebates. Do you see where it says "supplemental rebates" in the Montana response?

A. I do.

Q. Does Montana currently obtain supplemental rebates fog drug?

A. Yes, we do.

Q. When did Montana Medicaid begin receiving supplemental rebates for prescription drugs?

A. I believe like in January or February of last year, 2005.

Q. Okay. Item No. 5 on the same page requests information. I'll just read it:

"Has Montana performed any surveys, audits, or reviews to determine actual pharmacy acquisition cost during the past 10 years? If so, please describe in detail the timing, methodology and results. Please also provide copies of any such surveys, audits or reviews."

Could you please read Montana's response

EXHIBIT 16

UNITED STATES DISTRICT COURT FOR

THE DISTRICT OF MASSACHUSETTS

IN RE PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION	)	MDL NO. 1456
	)	Civil Action No. 01-CV-12257-PBS
THIS DOCUMENT RELATES TO: State of Montana v. Abbott Labs, Inc., et al., Civil Action No. CV-02-09-H-DWM	)	Hon. Patti B. Saris

DEPOSITION OF JAMES E. SMITH

Taken at Gough, Shanahan, Johnson & Waterman

33 South Last Chance Gulch

Helena, Montana

March 8, 2006

8:30 a.m

breakdown, either numbers or percentage-wise, of members that would be chain pharmacies versus independent pharmacies?

A. Well, in the -- in the State of Montana, there's about 200 retail pharmacies, and about 120 of them are independently owned, and 80, plus or minus, are chain drug stores. What I'm not sure about right now is the membership percentage from each of those categories, but just across the state, that's roughly the breakdown in retail. And most of the independent members -- or the independents are members in one way, shape, or form. Maybe less so with the chains. But actually, we've worked hard to get more participation from the employee pharmacists in the chain stores, and I think we're -- you know, we're doing okay at that.

Q. And who are the largest chains of pharmacies in Montana?

A. I think Albertson's is still the big one, with about 21 or 22 stores across the state, and they also own the eight Oscos that are in the state. Safeway is a pretty big chain. Wal-Mart and ShopKo.

with -- you know, even -- I think Wal-Mart has got five stores in the state, and ShopKo, about the same. I mean, that would make them a pretty big chain here.

Q. And of those roughly 200 retail pharmacies, do you have any idea of what the breakdown would be of urban pharmacies versus rural pharmacies?

A. Well, I know we've got a lot of them out in the rural areas of the state. I don't know. This would be a speculative guess, but half and half. I'd say half of those independents are in towns of less than 10,000, maybe even less than 5,000 people, rural settings. And the other half are in the cities of Montana.

Q. And how about the chain pharmacies?

A. Well, largely in the cities, yeah.

Q. And what is the mission of the MPA?

A. Oh, I think it's to -- I'm trying to remember. I should know it and be able to recite it verbatim.

Q. Yeah. I don't need you to recite it. I'm

in the reimbursement formula from AWP minus-10 percent to AWP minus-15 percent. Does that sound right?

A. It does -- Yeah, it does. I mean, I might have thought closer to 2003. It had something to do with that hearing in February of 2003 that I attended, I thought. But, yeah, it was discounted a little further in '02 or '03. I'm sure you know. I'll say '02.

Q. And how about for generic drugs; do you know what the reimbursement formula is under Medicaid?

A. Well, I think that's still at AWP minus-15 plus 4.40. I'm sorry, I should know this. My bosses at the Pharmacy Association would be distressed that I don't know it by heart.

But that's what we were looking at in 2003 in that hearing. As I recall, the Department's proposal was to go to AWP minus-25 percent on generics. And I think we -- Well, we were arguing against that, but it didn't happen, and I think the reason it didn't happen is because the Department

opted for creating the so-called preferred drug list instead. I think there was a favorable -- a Supreme Court decision having to do with the State of Maine that you might say authorized or enabled or allowed the states to make these preferred drug lists, and when that decision was made, I think the Department abandoned its formula change on generics and began working to develop this preferred drug list.

Q. And can you describe for me what this preferred drug list is? And I think you referred to it as a drug formulary early on.

A. That's my understanding, Mr. Duffy, that for each class of drugs, there would be a formulary so that there would only be one drug in a class that would be approved for dispensing and approved for the Medicaid standard reimbursement. So, you know, you're always -- I guess the cholesterol medicine always is used as an example. You know, they're not going to put Lipitor and Mevacor on the same formulary; it's going to be one or the other.

Q. And do you know how they determine which drug will be listed on the formulary?

bill?

A. Yes. Yep.

Q. Okay, we talked a bit about what's been referred to as equal access earlier. I'd like to talk a bit -- or ask you some questions about that again. Do you know what percentage of the prescriptions that are filled by Montana pharmacies were reimbursed through Medicaid?

A. No, I don't right off the top of my head.

Q. Would -- would a 25 percent figure be what you would expect or what your understanding is?

A. I would have guessed -- I was going to say I could guess less than a third. I would have maybe guessed in that neighborhood, 20 to 30 percent.

Q. And do you know, is there any significant variance of that from urban-based pharmacies to rural-based pharmacies in the state?

A. I would suspect that percentage is higher in rural communities with a greater proportion of poor or elderly.

Q. Any estimate on what it would be for rural communities or pharmacies?

there's no extra money for it; they're still getting that same Medicaid dispensing fee.

So I'm trying to answer yes, that whether it's poor, frail, elderly people or other Medicaid people with special needs, the pharmacists tell me that it's just a more intensive group of people to serve.

Q. In your role as the executive director of the MPA, what is your understanding of the financial situation that's faced by Montana pharmacies?

A. Well, I think they're operating on real low profit margins. The transition from a first-party cash marketplace to this third-party marketplace, third-party reimbursement over the last 10, 15 -- 15 years that I've been around, has been a very difficult transition for these people to withstand and undergo. I think if anything -- if there's any major reductions in those Medicaid dispensing fees, half those rural pharmacies are going to be gone within six months and the remaining half will be gone within the next year.

I think they've managed to stay open

through a variety of innovative business practices and good customer service. I mean, there's a pharmacy/Ace Hardware store up in Troy, Montana. There's a pharmacy/floral shop in Seeley Lake, Montana. In Deer Lodge, it's a pharmacy and probably one of the nicest little gift shops that you'd ever want to see. So they're trying to keep the doors open by selling other things out of their stores. And, you know, then they've got the health and beauty aids, the gift cards, they've got the over-the-counter products. I mean, all that stuff is helping to buoy them up in this era of shrinking reimbursements.

And I think the other thing they do in order to stay open and viable is try to provide a high level of customer service; you know, free deliveries, packing these medicines into, you know, weekly trays for people with special needs, stuff like that. But I think they're very much on the bubble right now.

Q. And I take it, from what you said, it would be fair to say that the Medicaid reimbursement

the explanation.

Q. And can you give me just a brief description of kind of the methodology that was used to conduct the survey?

A. Well, I had several discussions with the folks at the School of Business. I'm trying to remember the guy's name. But I told him what we were looking for, what kinds of information we were trying to get from this survey, and then based on those discussions, they crafted a questionnaire. And I think they beta tested it to a couple pharmacies, and then based on the feedback we got from that, we sent it out to all the pharmacies, all the retail pharmacies in the state and then awaited the responses and compiled them into this document.

Q. I'd like to talk a bit about some of the conclusions that were reached by this study. If you'll turn to page 2, the third full paragraph there, beginning with the second sentence of that paragraph, it reads, "Prescriptions for Montana Medicaid patients constitute almost 25 percent of the average Montana independent community pharmacy's

total prescription volume," and then in parentheses, "compared to 23 percent nationally."

Now, I know we talked a bit about this before. Again, that 25 percent figure, that would be consistent with your understanding?

A. Um-hum.

Q. And if you'd turn to the next page, page 3, the top of the page there, the sentence reads, "Based upon Montana DPHHS" -- and again, that's the Montana Department of Health and Human Services -- "statistics, a community pharmacist practicing in a rural Montana town may be one of only two or three providers of first contact care in the entire county."

Again, is that consistent with your understanding of the situation of the Montana pharmacies at this time?

A. Yes, it is. We say they're the most readily accessible health care providers.

Q. And if you'd turn to page 5 of the survey, down at the bottom of the page there, the second sentence of the paragraph at the bottom of the page

EXHIBIT 17

UNITED STATES DISTRICT COURT

THE DISTRICT OF MASSACHUSETTS

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IN RE PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION,

MDL NO. 1456

Civil Action No.

01-CV-12257-PBS

Hon. Patti B. Saris

THIS DOCUMENT RELATES TO:

State of Montana v. Abbott Labs, Inc., et al.,

Civil Action No. CV-02-09-H-DWM.

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DEPOSITION OF TIMOTHY P. STRATTON, PH.D.

Taken March 24, 2006

Scheduled for 9:00 a.m.

Reported By: Lori L. Morrow, RPR, CRR

BY MS. O'SULLIVAN:

Q. The court reporter has just handed you Exhibit Stratton 010 to your deposition, a multipage document that is not Bates numbered and is labeled "Findings from the Montana Pharmacy Association 2002 Survey of Montana Community Pharmacies." Will you please take a look at it?

A. I have completed reviewing this document.

Q. Have you seen it before?

A. I have.

Q. What is it?

A. This would have been my draft report to the Montana Pharmacists Association based on the data that was collected in the survey we have been discussing.

Q. Do you remember when you completed this draft report?

A. Right in December of 2002.

Q. Do you recall generally the conclusions you reached in your draft report?

A. I have to review those. I concluded that a reduction in the Montana Medicaid payments would

definitely impact the economic picture for Montana community pharmacies, particularly the independent pharmacies. It was possible that if respondents to the survey carried through on their -- on what they indicated in the survey, they would indeed have resulted in laying off part-time and possibly full-time pharmacy employees because of these cuts in Medicaid reimbursement. I then go on to suggest that Montana pharmacists should use this opportunity to renegotiate the dispensing fee with the state for Medicaid prescriptions, one that covered not only the cost for dispensing but one that allowed for a fair return independent of the drug cost.

Q. Were you just looking at page 8 under the heading "Conclusions" on Exhibit Stratton 010?

A. That is correct.

Q. Again, I have some specific questions going through the document. But just to start at a really basic level, what is a community pharmacy?

A. Community pharmacy is a retail pharmacy that is located in a town. It distinguishes from a chain pharmacy such as Walgreen's, Long's, Eckerd.

Q. Would you explain what you mean by that?
A. In the context of this particular study, using the term "average" to describe the average pharmacy, I guess, their income, wouldn't be as accurate, because some pharmacies were -- would be either very -- doing very well or doing very poorly. And so, statistically, we know that there's outliers. And they would drag the average then either higher or lower and may not accurately represent the average revenue, for example, of all community pharmacies that participated in the survey. Therefore, I recommended using -- and I didn't recommend. I used the median value, the middle value, which helps to reduce the influence of outliers on either end of that distribution.
Q. Looking at the next paragraph on page 3, seven lines down, do you see the sentence that begins "Based solely on dispensing fees"?
A. Yes, I do.
Q. Did you conclude that, "Based solely on dispensing fees recovered, the average responding pharmacy lost $2.25 on each Montana Medicaid

prescription dispensed, and nearly $4.00 on every Other Third Party prescription"?

A. That is correct.

Q. Why did you use the phrase "average" in that sentence?

A. There, I'm trying to describe the representative pharmacy. So we have this data from 80 different pharmacies around the state, and I was trying to construct a profile for the average pharmacy that responded to that particular survey.

Q. Would you turn to page 5 of your draft report?

A. I am there.

Q. Would you explain what the chart in Figure 2 represents?

A. Figure 2 is entitled the "Median Cost of Dispensing a Prescription, and Dispensing Fees for Medicaid and Other 3rd Party Payors Reported by Montana Community Pharmacies." The furthest bar on the left represents the dispensing cost. These were calculated by the individual pharmacy respondents and included as some of their survey data that they

submitted to us. And this looked at costs, including the cost of vials, labels, computers, staff in the dispensary department. The second bar, the middle bar, was the median Medicaid fee that was received by these pharmacies as reported by those pharmacies. And the far right bar, the darkest bar, is the third-party fee on average that was -- or the median, I'm sorry, third-party fee that was received by those pharmacies for filling third-party prescriptions.

Q. Does this chart reflect your conclusion that the median cost of dispensing a prescription was greater than the Medicaid fee for all different types of Montana pharmacies?

A. On average, yes.

MR. GAUDET: Objection.

BY MS. O'SULLIVAN:

Q. What was that conclusion based on?

A. Again, that conclusion was based on the Medicaid fees calculated from the state formula that we had access to and comparing that Medicaid fee to the dispensing cost reported by the pharmacies.

whole sentence deleted from the final report that is Exhibit Stratton 011?

A. I believe so, but let me check. I do not find that statement in the summary statement of the final report.

Q. I would like you to look at page 18 of Exhibit Stratton 011, the "Conclusions" section.

A. I am looking at that.

Q. Will you read the first sentence there?

A. "There is no doubt that the proposed reductions in Montana Medicaid payments will impact the bottom line of Montana community pharmacies, particularly independent pharmacies, and particularly independent pharmacies in rural communities."

Q. Is it fair to say that that conclusion is the same as the conclusion in the draft report that you authored?

A. That is correct.

Q. Is it fair to say that both the draft and the final report conclude that dispensing fees paid to pharmacies by Medicaid and Third Party Payors are

not sufficient to cover pharmacies' actual costs of dispensing drugs?

A. That is correct.

Q. And is it fair to say that the conclusion in the draft and the final are that a reduction in Montana Medicaid reimbursement could lead to closure of pharmacies in Montana?

MR. GAUDET: Objection.

THE WITNESS: That is what we speculated, yes.

BY MS. O'SULLIVAN:

Q. What was the -- well, you call it a speculation.

A. What I speculated.

Q. What was the basis for that?

A. Responses that we had from some of the respondents on the surveys, as I recall.

Q. Respondents to the pharmacy survey said that a reduction in Montana Medicaid reimbursement might lead them to close their pharmacies?

A. Let me back up for a moment on that.

Q. Okay.

A. I retract that statement. It does not appear we asked that on this survey. That was the survey done by my graduate student, as I recall, where a very small number of pharmacies surveyed were asked what they might have to do. So that was speculation on our part -- on my part.

Q. But it was not speculation in your report to conclude that dispensing fees paid to pharmacies by Medicaid and Third Party Payors were not sufficient to cover pharmacies' actual costs of dispensing drugs?

A. That is correct.

Q. That was your analysis based on the data?

A. That is correct.

Q. Do you still have a copy of the data that formed the basis for your analysis?

A. I believe so.

Q. Do you believe Dr. Polzin also has a copy of that data?

A. I have no way of knowing how long they retain their data.

Q. He had a copy of it at one point?

correct?

A. Yes, and hospitals and -- right.

Q. And you had access to information about how many pharmacists were in each county?

A. Correct.

Q. What was the source of information about the number of pharmacists per county in Montana?

A. That source could be the Montana State Board of Pharmacy. I believe that Montana Pharmacy Association also has a similar data base.

Q. Do you believe that is a true statement, that a community pharmacist practicing in a rural Montana town may be one of only two or three providers of first contact care in the entire county?

A. Yes.

Q. Page 5 of the report under "Estimated Dispensing Costs and Fees."

A. Yes, I see where you are.

Q. Will you read into the record the line "As can be seen." That's in the bottom paragraph --

A. Yes.

Q. -- third line. Will you read that, please?

A. "As can be seen from Table 1 and Figure 1, the average dispensing fee currently paid by Montana Medicaid covers less than half the cost of dispensing a Medicaid prescription, while the average dispensing fee paid by other third party payors covers less than one-third of the cost of dispensing."

Q. Do you agree with that statement?

A. I do.

Q. The next sentence goes on to say, "This shortfall is greater for rural community pharmacies." Do you also agree that that is a true statement?

A. I agree that's a true statement.

Q. Why is that?

A. The cost of doing business for community pharmacies in rural communities tends to be higher, and yet, there is no rural supplement provided in the Medicaid reimbursement for that.

Q. Put aside Exhibit Stratton 011. What is

EXHIBIT 18

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

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IN RE: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION	)	MDL No. 1456
----------	)	No. 01-CV-12257-PBS
This Document Relates to All Actions	)	
Defendant.	)	

September 28, 2004
DEPOSITION OF TINA WONG

Deposition of TINA WONG, taken on behalf of Johnson & Johnson, at 404 Fuller Avenue, Helena, Montana, commencing at 2:00 P.M., on Tuesday, September 28, 2004, before LESIA J. MERVIN, CSR No. 4753, RMR, Certified Realtime Reporter.

this on MON 3056 of Exhibit 2, under section 1(a), is this the section that governs the reimbursement per pharmaceutical product that you described to me earlier for brand names?

A. Right, at a retail pharmacy.

Q. At a retail pharmacy. Okay. We had talked earlier about looking at reimbursement rate of the AWP rate less 15 percent, and the Ridgeway reimbursement rate, which was AWP minus 23 percent. Is it your understanding that AWP less 15 percent is what the pharmacists -- is all passed through to the pharmacist, or that there's some margin in there that ESI retains as part of its pharmacy benefit management services?

MR. FEINBERG: Counsel, are you asking about the prices compared to the price paid by ESI to the pharmacy, or the price paid by the pharmacy to whoever it's getting the drug from?

BY MS. SCHOEN:

Q. The price paid by ESI to the pharmacy. But I can restate the question if it's unclear.

A. No, I think I was following. You know,

in our arrangement -- our reimbursement is strictly AWP less 15 percent to the pharmacy. And I'm not aware of what, you know, specifically ESI is reimbursing the pharmacy. It does in our contract talk about it could be less than our -- I don't know what it calls, but less or more than what we are reimbursing, but I don't know any specifics to that at all.

Q. Okay.

(Exhibit Wong 002 was marked for identification.)

BY MS. SCHOEN:

Q. Miss Wong, I'm showing you what's marked as Exhibit 2. Is this document familiar to you?

A. You know, I haven't seen this in so long. I'm sure I saw it at one time, but it's been a long time.

Q. Okay. Do you recognize it as to what it is?

A. Yes, I do.

Q. Okay. Can you tell me that?

A. It is the contract with Pharmacy Gold Inc. from 1994.

those amounts are not disclosed to you?

A. Right.

Q. Okay. So it was your understanding, and I think you testified to this earlier, but just to make sure I'm clear, that ESI may be paying pharmacies either more or less than what you're paying to ESI for a particular claim or a particular pharmaceutical product?

A. Yes.

Q. Is that your understanding generally?

A. Right. We've never -- when we did our new contract with them in 2002, we did talk to them briefly about that, and I guess they assured us that it wasn't -- because we were, I guess, maybe a little uneasy that they were being very aggressive with Montana pharmacies, and so we wanted to know -- or I guess we didn't want to know specifically what the reimbursement was, but I guess we wanted to know from them that the price -- we understood the price may vary, but it does not vary a lot, just because we didn't want the pharmacies to, you know, be hurt by getting a deeper discount off of AWP.

EXHIBIT 19

MONTANA

Methods & Standards
for Establishing
Payment Rates,
Services 12 a.,
Outpatient Drug Services

Reimbursement for drugs shall not exceed the lowest of:

1. The Estimated Acquisition Cost (EAC) of the drug plus a dispensing fee, or;

2. The Federal Upper Limit (FUL), Maximum Allowable Cost (MAC) of the drug, in the case of multi-source (generic), plus a dispensing fee, or;

3. The provider's usual and customary charge of the drug to the general public.

Exception: The FUL or MAC limitation shall not apply in a case where a physician certifies in his/her own handwriting the specific brand is medically necessary for a particular recipient. An example of an acceptable certification is the handwritten notation "Brand Necessary" or "Brand Required." A check off box on a form or rubber stamp is not acceptable.

The EAC is established by the state agency using the Federal definition of EAC as a guideline: that is, "Estimated Acquisition Cost" means the state agency's best estimate of what price providers generally pay for a particular drug.

The EAC, which includes single source, brand necessary and drugs other than multi-source, is established using the following methodology:

Drugs paid by their Average Wholesale Price (AWP) will be paid at AWP less 10%. The policy for the reimbursement of Direct Price (DP) drugs (the price charged by manufacturers to retailers) is the current direct price (the direct price in effect on the date of service for the claim.

The MAC for multiple source drugs will not exceed the total of the dispensing fee established by the Department and an amount that is equal to 150 percent of the price established under the methodology set forth in 42 CFR 447.331 and 447.332 for the least costly therapeutic equivalent.

A variable dispensing fee will be established by the state agency, by using the results of a cost survey of pharmacy's operational costs. A pharmacy may be assigned an enhanced dispensing fee to cover the additional costs associated with packaging "unit dose" prescriptions.

Provider dispensing fee(s) are available on-line in the Medicaid Management Information System (MMIS) provider file and in the Medicaid Prescription Drug Card System (PDCS) provider plan file.

TN 95-01
Superseedes TN #88(10)02 Approved 03/27/95 Effective 10/01/94

EXHIBIT 20

BEFORE THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES OF THE STATE OF MONTANA

In the matter of the amendment of ARM 37.86.1101 pertaining to outpatient drugs definitions	))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On July 26, 2000, at 10:00 a.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of the above-stated rule.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on July 17, 2000, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970; Email dphhslegal@state.mt.us.

2. The rule as proposed to be amended provides as follows. Matter to be added is underlined. Matter to be deleted is interlined.

37.86.1101 OUTPATIENT DRUGS, DEFINITIONS

~~(1)~~(4) "Outpatient drugs" means drugs which are obtained outside of a hospital.

(2) "Legend drugs" means drugs that federal law prohibits dispensing without a prescription.

(3) "Maximum allowable cost (MAC)" means the upper limit the department will pay for multi-source drugs. In order to establish base prices for calculating the maximum allowable cost, the department hereby adopts and incorporates by reference the methodology for limits of payment set forth in 42 CFR 447.331 and 447.332 (1996). The maximum allowable cost for multi-source drugs will not exceed the total of the dispensing fee established by the department and an amount that is equal to the price established under the methodology set forth in 42 CFR 447.331 and 447.332 for the least costly therapeutic equivalent that can be purchased by pharmacists in quantities of 100 tablets or capsules or, in the case of liquids, the commonly listed size. If the drug is not commonly available in quantities of 100, the package size commonly listed will be the accepted quantity. A copy of the above-cited regulations may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, ~~Montana~~ MT, 59620-2951.

~~(4)~~(1) "Estimated acquisition cost (EAC)" means the cost of drugs for which no MAC price has been determined. The EAC is the department's best estimate of what price providers are generally paying in the state for a drug in the package size providers buy most frequently. The EAC for a drug is~~the direct price (DP) charged by manufacturers to retailers. If there is no available DP for a drug or the department determines that the DP is not available to providers in the state, the EAC is the average wholesale price (AWP) less 10%.~~ :

(a) the direct price (DP) charged by manufacturers to retailers;

(b) if there is no available DP for a drug or the department determines that the DP is not available to providers in the state, the EAC is the average wholesale price (AWP) less 10%; or

(c) the department may set an allowable acquisition cost for specified drugs or drug categories when the department determines that acquisition cost is lower than (1)(a) or (b) based on data provided by the drug pricing file contractor.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA

3. Medicaid provides health care to low-income Montanans. The program is jointly funded by the federal and state government using public monies. One benefit provided by Medicaid is prescription drugs. In order to administer the program efficiently and contain costs, if possible, the rules regarding drug acquisition costs need clarification in order to avoid overpayment of drug claims.

The proposed amendments change the definition of "estimated acquisition cost (EAC)" to allow the department to use as the EAC a drug price that reflects the drug's acquisition cost more accurately than the direct price (DP) or average wholesale price (AWP) less 10%.

An additional definition of EAC has been added to ARM 37.86.1101 to allow the department to use as the EAC an allowable acquisition cost (AAC) which is different from the DP and the AWP less 10%. This change allows the department to set the AAC when there is evidence that the DP and discounted AWP do not accurately reflect the provider's acquisition cost.

The concern regarding accurate pricing information arose as the result of a whistle-blower fraud investigation conducted by the Office of the Inspector General and several State Medicaid Fraud Control Units. The investigation revealed "a pattern of misrepresentations by some drug manufacturers of the average wholesale prices and wholesale acquisition costs of certain of their products". The misrepresented prices result in inflated claims being paid by Medicaid.

To remedy the inaccurate pricing, representatives of the State Medicaid Fraud Control Units worked with First DataBank, Inc. (FDB), to develop procedures to improve the accuracy and validity of the pricing information provided to states. Specifically, FDB agreed to base average wholesale prices on market prices, rather that prices identified by manufacturers. Additionally, FDB will not report a price for a product unless its manufacturer has certified the completeness and accuracy of the pricing information submitted. Comparisons of FDB's new prices and the prior average wholesale prices demonstrated that significant overcharges to Medicaid have occurred. The proposed rule amendments are necessary to prevent overbilling on drugs in the future, but still reimburse providers fairly, including their cost of acquisition.

The Department considered maintaining the current reimbursement methodology. However, the proposed rule amendments implement a pricing system which better reflects the provider's costs while still ensuring a fair price to the Medicaid program. Thus, the Department chose to implement these changes.

Based on our review of this issue, discussions with providers, and the experience of other states, the Department has determined that it is necessary to revise the current drug reimbursement methodology to include an additional methodology that allows use of the new prices determined by FDB without further discounting. To use the current pricing methodology of AWP less 10% could result in reimbursement less than the provider's acquisition cost. Because the intent of the revised rule is to provide more accurate reimbursement to providers for drugs, the rules will be applied retroactively to July 1, 2000.

The Department estimates that the proposed amendments will result in a 24% decrease in expenditures for drugs. Based on the fourth quarter of 1999, this would equate to a savings of approximately $295,000 in state and federal funds per fiscal year. There are approximately 300 pharmaceutical providers which may be affected by this proposed rule amendment.

4. Interested persons may submit their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to Kathy Munson, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, no later than 5:00 p.m. on August 1, 2000. Data, views or arguments may also be submitted by facsimile (406) 444-1970 or by electronic mail via the Internet to dphhslegal@state.mt.us. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

5. The Office of Legal Affairs, Department of Public Health and Human Services has been designated to preside over and conduct the hearing.

Dawn Sliva
Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State June 19, 2000.